Rev 5/06

SUPPORTS FOR COMMUNITY LIVING
STATEMENT OF SERVICES TO BE PROVIDED

AGENCY NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: _____

I/WE OF THE: _____
(AGENCY)

wish to provide the following COVERED SERVICES (check all that apply):

1. ☐ Adult Day Training
2. ☐ Adult Foster Care
3. ☐ Assessment/Reassessment
4. ☐ Behavior Support
5. ☐ Case Management
6. ☐ Children's Day Habilitation
7. ☐ Community Living
8. ☐ Family Home
9. ☐ Group Home
10. ☐ Occupational Therapy
11. ☐ Physical Therapy
12. ☐ Psychological Services
13. ☐ Respite
14. ☐ Speech Therapy
15. ☐ Staffed Residence
16. ☐ Supported Employment

Please return form to:
KY Medicaid Provider Enrollment
P.O. Box 2110
Frankfort, KY 40602-2110